

# Northwest Center for Outcomes Research in Older Adults: A VA HSR&D Center of Excellence



Medical Centers - Seattle, WA & Portland, OR

Winter 2000

*Affiliated with the University of Washington School of Public Health and Community Medicine,  
Seattle, WA & Center for Health Research (Kaiser Permanente), Portland, OR*

## **ASSESSMENT OF VITAL STATUS IN DEPARTMENT OF VETERANS AFFAIRS NATIONAL DATABASES: COMPARISON WITH STATE DEATH CERTIFICATES**

**Jason A. Dominitz, MD, MHS, Charles Maynard, PhD, and Edward J Boyko, MD, MPH**

Department of Veterans Affairs (VA) national databases contain extensive information about health care services received by veterans in VA facilities, including information on veterans' current vital status. This important information can be used scientifically to study a variety of questions of interest to epidemiologists and health services researchers, such as mortality among veterans with lung disease or colorectal cancer. The purpose of this study is to determine the extent to which VA vital status information agrees with Washington State death certificates.

Two study populations were compiled. First, from the Patient Treatment File (PTF), there were 24,929 individuals who either died during hospitalization or were discharged from one of three Washington State VA medical centers between January 1, 1994 and December 31, 1997. This computerized record of every VA hospital discharge was created in 1970 and is updated biweekly. We excluded 5448 individuals who, according to the PTF, were not Washington State residents. This resulted in 19,481 Washington State resident veterans who were hospitalized in VA facilities. Second, using the VA out-

patient clinic file (OPC), we identified 33,602 unique Washington State resident veterans who were seen as outpatients in Washington State VA clinics during fiscal year 1997. Veterans who were hospitalized, and therefore included in the first study population, were excluded.

The PTF reports the date of death for individuals who were hospitalized in VA facilities (including out of hospital deaths), so vital status was first ascertained from this file. Vital status was also determined from the BIRLS death file. This database identifies deceased veterans who received VA benefits. The BIRLS is updated quarterly from information gathered from a variety of information sources inside and outside the VA, including the Social Security Administration.

Washington State death certificates were obtained in electronic form from the Center for Health Statistics of the Washington State Department of Health. The file contains records of all deaths that occurred in Washington State for a given year, as well as death records for residents who died out of state.

The kappa statistic was used to assess the overall agreement be-

tween the VA and Washington State death certificates. To compare decedent characteristics according to source of death information, the chi-square statistic was used for categorical variables and one way analysis of variance for continuous variables such as age.

### *Results*

From the 19,481 veterans who were hospitalized in VA facilities in Washington State, there were 3606 deaths identified from either the VA and/or Washington State sources (19% of all veterans). There were 1446 (43.8%) deaths identified only in the BIRLS, 88 (2.7%) deaths identified only in the PTF, and 1770 (53.6%) deaths were in both VA files. There were 302 veterans who appeared in Washington State records but not in VA files (8.3% of all deaths), and there were 196 veterans who were identified in VA files, but not Washington State files (5.4% of all deaths). There were 3108 individuals who appeared in both files (86.2% of all deaths), and 15,875 who were not deceased according to both sources (81% of all veterans).

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Emblem: "Soul Catcher" ...a Northwest Coast Indian symbol used to ward off spirits that brought physical or mental illness. Artist: Marvin Oliver.

The overall agreement between VA and Washington State databases regarding mortality status was excellent ( $\kappa=0.91$  [95% confidence interval: 0.90, 0.92],  $p<0.0001$ ). Using the Washington State database as a "gold standard," the sensitivity of the VA database is 91.1% for identifying deaths, while the positive predictive value is 94.1% and the negative predictive value is 98.1%.

Despite this high level of agreement, there were 302 veterans who were deceased according to Washington State records only. There were 1258 veterans who died in VA hospitals and 69 (5.5%) did not appear in the BIRLS database; there were 441 veterans who died in non-VA hospitals and only 1 (0.3%) did not appear in the BIRLS. These 69 missing in the BIRLS were all picked up by the PTF. The majority of deaths identified in both databases occurred within 30 days of the last hospital discharge, while deaths found in only one database tended to occur more than two months after the last discharge.

From the 33,602 veterans who were seen only as outpatients in VA facilities in Washington State, there were 533 deaths identified from either the VA and/or Washington State sources (1.6% of all veterans). For outpatient veterans, the BIRLS death file ascertained a much lower proportion of deaths in the Washington State files compared with inpatient veterans. The overall agreement between VA and Washington State databases among outpatients was good ( $\kappa=0.82$  [95% confidence interval: 0.79, 0.85],  $p<0.001$ ). Using the Washington State database as a "gold standard," the sensitivity of the VA database is 73.5% for identifying outpatient deaths, while the positive predictive value is 93.2% and the negative predictive value is 99.6%. Veteran deaths identified only in the VA files were younger, while deaths recorded only in Washington State files were less likely to be service connected or receive a VA pension or other compensation.

### *Discussion*

Our study demonstrates that VA death files are able to ascertain over 91% of hospitalized veteran deaths occurring between 1994 and 1997. However, only 73.5% of deaths among veterans seen only as outpatients were recorded in the VA files. As the proportion of non-service connected veterans who do not receive compensation or pension was similar among inpatients (47%) and outpatients (44%), the cause for this discrepancy is uncertain.

Fisher et al. compared mortality ascertainment obtained from the PTF and BIRLS with that of the National Death Index (NDI) for a cohort of 17,118 male veterans hospitalized in 1970 or 1971 (2). For the 4246 deaths identified between 1979 and 1988, the sensitivities of the BIRLS, PTF, and NDI were 94.5%, 33.0%, and 96.7% respectively. The negative predictive value of the VA databases combined was 97%. Boyle and Decoufle, however, found much lower mortality ascertainment rates for the VA files (3). Using a cohort of 18,313 randomly selected Vietnam-era veterans, they determined that only 28% of deaths during 1965-1971 and 89% of deaths during 1972-1981 were identified using VA files. In their study, the BIRLS was more likely to miss the deaths of veterans without an honorable discharge or with lower rank.

Page and Braun estimated that the BIRLS mortality ascertainment was 95.4% complete in their study of a cohort of nearly 32,000 World War II veteran twins followed from 1946 through 1990 (1). In a 1992 letter to the editor, Page reports that 92.4% of deaths among World War II veterans in Texas in 1980 were accurately reported to the VA (6). This rate is essentially the same as our finding in Washington State. Page et al. also determined the completeness of VA death reporting using a sample of known veteran deaths among males born between 1936 and 1955 (4). Using vital statistics from 8 states and New York City, they determined that VA death reporting is approximately 90% complete when used alone, and 96% complete when combined with Social Security Administration files.

There are at least two reasons why agreement may be better in the study by Fleming et al. (5). First, their report considered veterans 65 years and older who were hospitalized in either VA or Medicare facilities in New York or New England for one of two medical conditions including acute myocardial infarction or hip fracture or one of eleven surgical procedures such as coronary artery bypass surgery. Second, non-service connected veterans without compensation or pension accounted for 42% of the deaths in this study and almost 50% of the hospitalizations in Washington State facilities. Information on this particular group of veterans was not reported in the Fleming study. These non-service connected veterans appear to be less likely to have their deaths recorded in VA databases. In matching the PTF and BIRLS files, erroneous matches were possible, although we

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**Every NR, Fihn SD, Sales AE, Keane A, Ritchie JR, "The Quality Enhancement Research Initiative in Ischemic Heart Disease: A quality initiative from the Department of Veterans Affairs" Medical Care, 2000, Vol. 38 (6 Suppl 1): 49-59.**

Despite the dramatic fall in ischemic heart disease (IHD) mortality rates over the last 3 decades, it remains the number one cause of death in the United States, and one of the most frequent indications for care by the US Department of Veterans Affairs. National practice guidelines have been developed and disseminated both by societies that specialize in cardiology and within the Veterans Health Administration. Despite these efforts, a substantial minority remains of patients with IHD who are not treated with guideline-recommended therapies. The Quality Enhancement Research Initiative in IHD is a Veterans Health Administration-sponsored initiative to address the gap between guideline-recommended therapies and actual Department of Veterans Affairs practice. Because guideline development for patients with IHD is relatively mature, the Quality Enhancement Research Initiative in IHD will concentrate on measuring existing practices, implementing interventions, and evaluating outcomes in veterans with IHD. Measurement of existing practices will be evaluated through analyses of existing Veterans Affairs databases developed for the Continuous Improvement in Cardiac Surgery Program, as well as data collected at the Center for the Study of Practice Patterns in veterans with acute myocardial infarction. To measure existing practices in outpatients with IHD, we plan to develop a new database that extracts electronic data from patient laboratory and pharmacy records into a relational database. Interventions to address gaps between guideline recommendations and actual practice will be solicited and implemented at individual medical centers. We plan to emphasize point-of-care electronic reminders as well as online decision support as methods for improving guideline compliance.

**Mayfield JA, Reiber GE, Nelson RG, Greene T, "Do foot examinations reduce the risk of diabetic amputation?" Journal of Family Practice, 2000, Vol. 49:1-6.**

**BACKGROUND:** Foot examinations are widely recommended as a means to reduce amputation risk, but no investigators have studied their independent effect on this outcome.

**METHODS:** We conducted a population-based case-control study of primary care provided to Pima Indians from the Gila River Indian Community. Sixty-one Pima Indians with type 2 diabetes and a first lower-extremity amputation between January 1, 1985, and December 31, 1992, were compared with 183 people who had no amputation by December 31, 1992. The type of foot examination conducted, comorbid conditions, and foot risk factors present in the 36 months before the pivotal event were abstracted from medical records. All ulcer care was excluded. The independent effect of foot examinations on the risk of amputation was assessed by logistic regression.

**RESULTS:** During the 36 study months, 1857 foot examinations were performed on 244 subjects. The median number of preventive foot examinations was 7 for case patients and 3 for control patients. After controlling for differences in comorbid conditions and foot risk conditions, the risk of amputation for persons with 1 or more foot examinations was an odds ratio (OR) of 0.55 (95% confidence interval [CI], 0.2-1.7;  $P=.31$ ). The risk of amputation associated with written comments of nonadherence with therapeutic foot care recommendations or diabetic medication was an OR of 1.9 (95% CI, 0.9-4.3;  $P=.10$ ).

**CONCLUSIONS:** Our study failed to demonstrate that foot examinations decrease the risk of amputation in Pima Indians with type 2 diabetes. However, foot examinations detect high-risk conditions for which specific interventions have been shown to be effective in reducing amputation risk.

**Saha S, Taggart SH, Komaromy M, Bindman AB, "Do patients choose physicians of their own race?" Health Affairs, 2000, Vol. 19: 76-83.**

This study seeks to determine whether minority Americans tend to see physicians of their own race as a matter of choice or simply because minority physicians are more conveniently located within predominantly minority communities. Using data from the Commonwealth Fund 1994 National Comparative Survey of Minority Health Care, we found that black and Hispanic Americans sought care from physicians of their own race because of personal preference and language, not solely because of geographic accessibility. As minority populations continue to grow, the demand for minority physicians is likely to increase. Keeping up with this demand will require medical school admissions policies and physician workforce planning to include explicit strategies to increase the supply of underrepresented minority physicians.

## WHAT'S HAPPENING AT THE NW HSR&D CENTER OF EXCELLENCE

### Recent Career Development Awards

David Au, MD, a Senior HSR&D MD Postdoctoral Fellow was recently approved for his Research Career Development (RCD) Award to begin 7/01. This award is for a three-year period and is designed to provide salary and research support to a fully-trained clinician who is entering, or has recently entered, a research career. The title of his application was "Health Outcomes, Status and Quality of Care Among Patients with COPD." Dr. Au's research focus is on the quality of care given to patients with COPD. Specifically, he is interested in the cardiovascular outcomes and quality of care given to these patients at the end of life.

Other approved Career Development Awards for HSR&D Investigators include Dr. Marcia Burman's HSR&D CDA, "Cardiovascular Guidelines: Compliance Measure Development and Clinical Outcomes," and Dr. Bevan Yueh's HSR&D CDA, "Cost-Effectiveness of Hearing Amplification."

Kathy Bradley, MD, MPH, has been awarded two Career Development Awards, one with NIH, "Effectiveness of Primary Care Alcohol Interventions," and one with the Robert Wood Johnson Foundation, "Evaluation of an Alcohol Screening Program in a High-Risk Female Population."

### ART 2000 – The Annual Report Template Database

HSR&D Centers of Excellence are required to submit an annual report of center activities and investigators are required to submit abstracts for an annual

HSR&D Progress Reports Book. These reports and the ART database, which is used to collect the information, are extensively used by HSR&D Headquarters during the year to respond to requests for information from Congress and others.

Thanks to major efforts on the part of our core staff who collected information and entered it in ART (Monica Hayes, Jane Summerfield and Pat Tulip) and the investigators who wrote the narrative pieces, our center's FY2000 annual report is done and all abstracts for the Progress Reports Book have been submitted through ART.

In FY2000, we added new core investigators (Dr. Marcia Burman - Seattle, Drs. Mark Helfand and Jackilen Shannon - Portland), new professional staff (Jeff Todd-Stenberg - database administrator and Jane Summerfield - Administrative Officer); said goodbye to two core investigators (Drs. Nathan Every and Don Martin); increased our total funding from \$9,075,721 to \$9,615,033; and participated in 127 active research projects.

Keeping track of all the information related to these extensive activities and providing the information in a variety of settings is the purpose of ART. ART uses continue to grow. Our goal this coming year is to streamline the collection of information to make it as easy as possible for everyone involved in the process.

### New Investigators from Portland

Mark Helfand is a VA staff physician and the director of the Oregon Health Sciences University (OHSU) Evidence-

Based Practice Center. This Center is funded by the Agency for Healthcare Research and Quality for four studies on topics including diagnosis and management of osteoporosis and cost effectiveness of echocardiography and carotid ultrasound in management of stroke.

Dr. Jackilen Shannon, is an investigator with HSR&D and an Assistant Professor with the OHSU Department of Public Health and Preventive Medicine. She is a nutritional epidemiologist and plans to focus her research on the associations of diet and gene with reference to cancer prevention.

### Post PhD Postdoctoral Fellowship in Health Services Research

The Postdoctoral PhD position in HSR&D at the VA Medical Center/University of Washington will begin October 2001. Fellows engage in full-time research and related educational activities. Faculty provide expertise in areas of interest including: epidemiology, ambulatory care, outcomes research, economics, quality of care, geriatrics, long-term care, ethics and health policy. The stipend is \$37,000 per year. More information can be found on our website. U.S. Citizenship is required. A statement of research interests, specific aims for a research project of interest, curriculum vitae, and three letters of references should be sent by April 2 to: Gayle Reiber, Ph.D., HSR&D, VA Puget Sound Health Care System (152), 1660 South Columbian Way, Seattle, WA 98108.

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## FELLOWS' PROFILES

### **Deborah Kasman, MD**

Deborah is a second year HSR&D ambulatory care fellow. Her major interests include exploring the doctor-patient relationship, medical education during the clinical years of training, and physician well being. Deborah is currently doing a qualitative study of emotional experiences during medical training in the hospital setting, in addition to a quantitative survey on physician's satisfaction relative to their expectations and their personal self-care habits.

Deborah is originally from Chicago, IL, with an undergraduate degree in Human Biology from Brown University, RI. After taking time off to live on a kibbutz, travel, and work in an electrophysiology research lab, she attended medical school at UNC, Chapel Hill and completed a Family Practice Residency at the University of Washington in Seattle. She then served as a family physician for 11 years, serving a diverse population in an inner city practice. She explored travel, photography, mountain climbing and bicycling during those years.

Deborah is the proud mother of a 6-year old daughter and 4-year old son. She enjoys writing stories and some poetry. Her current hobbies include gardening, hiking, jogging and being with her kids.

### **Jane Tornatore, PhD**

Jane Tornatore is a first year postdoctoral fellow in HSR&D. Jane received her PhD in family social science and family therapy from the University of Minnesota in 1998. She has worked on gerontological research since 1993, and has experience in both

quantitative and qualitative research. Before moving to Seattle, Jane was the project director and co-investigator of Partners in Caregiving, a NINR-funded study which tested educational programs for family caregivers of persons with dementia living in the community. Before that, Jane was the project coordinator of the Minnesota research in the NIA-funded national study of nursing home Alzheimer's special care units. She is currently working on the Hartford Foundation-funded Community Residential Care study (Dr. Susan Hedrick, PI) which examines types of residential living for the elderly. Her particular interest is in what types of settings are best for elders who are cognitively impaired.

Going to the theatre is one of Jane's favorite activities. She also enjoys playing soccer, learning to sing Latin in a Medieval Women's choir, and looking for a good yoga class. Having lived in the plains state of Minnesota, Jane really likes having a view of Mt. Rainier out her office window.

### **Denver Lewellen, PhD**

Denver Lewellen, a second year research fellow in HSR&D, was trained in medical anthropology with a primary interest in understanding the barriers to health care that certain patient populations experience. He is currently PI on a research project designed to investigate experiences of WWII-era veterans at VA. He has also been studying the role of brief interventions in VA doctor/patient interactions related to drug and alcohol abuse.

Before coming to Seattle, Denver completed his doctoral de-

gree in anthropology at the New School for Social Research in New York City. As a graduate student, he held health services research posts at the Institute for Health, Health Care Policy and Aging Research at Rutgers University in New Brunswick, New Jersey and the Department of Social Studies in Medicine at McGill University in Montreal, Quebec. As recipient of the Canadian Embassy Graduate Fellowship Award, Denver lived and conducted fieldwork in Montreal for the academic year 1997-1998. His dissertation compared the lived realities of HIV patients and their health providers in New York City with a similar population in Montreal. By conducting research in both countries, Denver was able to examine how the differences in health care systems impacted patient and provider HIV experiences and needs.

At the postdoctoral level, Denver has worked in the area of behavioral health. In 1999 he joined the Arizona Integrated Treatment Consensus Panel, an advisory board created for the purpose of implementing best practice models of integrated treatment for persons with co-occurring disorders in Arizona. The Consensus Panel was the recent recipient of the 2000 Spirit of Excellence Award by the State of Arizona Governor's office.

As an anthropologist, Denver enjoys the experience of immersing himself in foreign cultures. In addition to his year in Montreal, he has traveled throughout China and parts of East Africa. He has plans to visit either Viet Nam or India in the coming year.



### **CHARLES MAYNARD, PHD**

Charles (Chuck) Maynard has been an investigator at the VA Puget Sound Health Care System HSR&D since January 1999, although he has been affiliated with the University of Washington since 1975. He received his undergraduate degree in sociology from Whitman College and masters and PhD degrees in social work and sociology from Washington State University and the University of Washington. While at the latter institution, he has worked in a number of departments or schools, including social work, biostatistics, medicine, and health services.

Chuck's major research interest is cardiovascular data analysis, particularly as it applies to determinants of cardiovascular procedure utilization and the improvement of medical decision making for acute coronary syndromes. A secondary interest includes services research in substance use disorders. His major methodological focus generally is on large databases and specifically on VA databases, including the patient treatment and outpatient care files. Much of this database work is supported by the Seattle Epidemiologic Research Information Center (ERIC), where he works with a variety of investigators who need advice concerning VA databases. In addition, he is Acting Research Coordinator for the Ischemic Heart Disease QUERI while Dr. Steve Fihn is on sabbatical in the Netherlands. He feels very fortunate to work with colleagues who have a range of research interests related to improving the health of veterans.

Chuck's wife of 10 years, Judy Garni, is a nurse and sales representative for the Guidant Corporation. They are both blessed by the presence of their daughter, Julia, who is 8 years old and in the second grade. Chuck's outside interests include running, water sports, and teaching Sunday school.

# Northwest HSR&D Center of Excellence

## Core Staff

Stephan D. Fihn, MD, MPH  
*Director, HSR&D*

Susan C. Hedrick, PhD  
*Associate Director, Seattle Site*

David H. Hickam, MD, MPH  
*Associate Director, Portland Site*

Katharine A. Bradley, MD, MPH  
*Investigator*

Marcia L. Burman, MD, MPH  
*Investigator*

Michael K. Chapko, PhD  
*Investigator*  
*Research Review Coordinator*

Chaun-Fen Liu, PhD  
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Matthew L. Maciejewski, PhD  
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*Information Dissemination Coordinator*

Charles Maynard, PhD  
*Investigator*

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Gayle E. Reiber, MPH, PhD  
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*Administrative Officer*

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*Staff Assistant*

Nancyjean Tripp  
*Program Secretary*

Pat Tulip  
*Program Assistant*

Bill Young  
*Network Manager*

Greg Gilbo  
*Computer Specialist*

## HSR&D Newsletter

The Northwest HSR&D COE Newsletter is published quarterly. Contributions for publication should be sent to:

HSR&D Newsletter (152)      Main Office: (206) 764-2430  
 Monica Hayes, Editor      (206) 764-2611  
 VA Medical Center      Fax: (206) 764-2935  
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 Seattle, WA 98108      e-mail: [monica.hayes@med.va.gov](mailto:monica.hayes@med.va.gov)  
 HSR&D Web site: <http://www.puget-sound.med.va.gov/hsrd>

## HSR&D Deadlines

Local deadline for proposal review is two weeks prior to Research Review Committee meeting and two months prior to VAHQ deadline. Review Committee meets on 1st Friday of each month.

## VAHQ Deadlines

**Letters of Intent (LOI):** Accepted any time, reviewed monthly. Guidelines in Instructions for Submitting a Letter of Intent, January, 2000.

**Investigator-Initiated Research Proposals (IIR):** Due May 1 and November 1. An approved LOI is required prior to submission. Guidelines in Instructions for Preparing Investigator-Initiated Research Proposals, October, 1997.

**Nursing Research Initiatives (NRI):** Due December 1 and June 1. An approved LOI is required prior to submission. Guidelines in Instructions for Preparing Investigator-Initiated Research Proposals, October, 1997. Refer to NRI Announcement January, 2000 which shows NRI modifications to IIR Guidelines.

**Research Career Scientist:** March 1 and September 1. Guidelines in RCS Directive VHA Notice 98-02.

**Career Development:** Due February 15 and August 15. Must have approved LOI prior to submission; due November 1 and May 1. Guidelines in CDA Directive VHA 1201.8.

*For current guidelines and forms, please refer to [www.va.gov/resdev](http://www.va.gov/resdev)*

## Phone Listings for HSR&D Service, VA Headquarters

Director - John Demakis, MD	(202) 273-8287
Deputy Director - Shirley Meehan, MBA, PhD	(202) 273-8287
Assistant Director, Operations - Rita Lysik	(202) 273-8242
Assistant Director, Research Initiatives & Analysis - Jay Freedman, PhD	(202) 408-3662
Career Development Program Manager - L. Robert Small, Jr.	(202) 273-8256
FAX Number	(202) 273-9007



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carefully checked matches using social security number, last name, first and middle initial, gender, and date of birth. It is not surprising that the mean age of death is lower for those veterans listed as deceased exclusively in the VA files. There is less incentive to report deaths of persons under retirement age as they are less likely to be eligible for social security benefits.

In summary, in this study of over 19,000 veterans hospitalized in Washington State during 1994-1997, mortality ascertainment using the VA death files had a high level of agreement with state death files ( $\kappa=0.91$ ). However, the VA files were less valid for veterans with non-service connected disability who were not receiving other VA compensation and was particularly invalid for veterans seen exclusively as outpatients. The BIRLS should not be used to determine vital status of patients seen exclusively as outpatients. For researchers who rely on VA databases to determine vital status, it is important to consider supplementing VA death records with other sources, such as state death files or the National Death Index, especially considering that the probability of ascertainment is affected by demographic characteristics that may be related to mortality (i.e. age and service-connected status). Also, when assessing veterans' vital status, both the BIRLS and the PTF should be used.

1. Page W, Braun M, Caporaso N. Ascertainment of mortality in the US veteran population: World War II veteran twins. *Mil Med.* 1995;160(7):351-5.
2. Fisher S, Weber L, Goldberg J, Davis F. Mortality ascertainment in the veteran population: alternatives to the National Death Index. *Am J Epidemiol.* 1995;141(3):242-50.
3. Boyle C, Decoufle P. National sources of vital status information: extent of coverage and possible selectivity in reporting. *Am J Epidemiol.* 1990;131(1):160-8.
4. Page W, Mahan C, Kang H. Vital status ascertainment through the files of the Department of Veterans Affairs and the Social Security Administration. *Ann Epidemiol.* 1996;6(2):102-9.
5. Fleming C, Fisher E, Chang C, Bubolz T, Malenka D. Studying outcomes and hospital utilization for the elderly: the advantages of a merged data base for Medicare and Veterans Affairs hospitals. *Med Care.* 1992;30:377-91.
6. Page W. VA mortality reporting for World War II army veterans (Letter). *Am J Public Health.* 1992;82(1):124-125.

*Summary of "Assessment of Vital Status in Department of Veterans Affairs National Databases: Comparison with State Death Certificates" forthcoming in Annals of Epidemiology by Dominitz, Maynard, and Boyko with permission from Elsevier Science.*

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## 21 Abstracts Accepted for Presentation at 19th Annual HSR&D Meeting

### Oral Presentations

- VA primary care patients who screen positive for at-risk drinking: the relationship of readiness to change to severity of alcohol-related problems, Kathy Bradley, MD, MPH
- Utilization of Department of Veterans Affairs healthcare services by veteran receiving publicly funded substance abuse services in Washington State, Dan Kivlahan, PhD
- Process of care in innovative and traditional treatments for depression in VA primary care, Susan Hedrick, PhD
- Hepatitis C virus (HCV) prevalence, access to care, and psychiatric co-morbidities in the NW Network, Kristy Straits-Troster, PhD
- Using the RxRisk as a case-mix descriptor - test-retest reliability, Kevin Sloan, MD
- Race, treatment and survival of veterans with esophageal cancer, Jason Dominitz, MD
- Patient attitudes regarding clinicians using computers during clinic appointments, Ashley Hedeem, MD, MPH
- Creating an operational definition of degree of clinical integration, Anne Sales, MSN, PhD
- Effect of clinical integration on patient outcomes in VA cardiology, Anne Sales, MSN, PhD
- Factors affecting choice of community residential care setting, Anne Sales, MSN, PhD

### Workshop

- Human Subjects Issues: Operational Lessons in Conducting Multi-site and Multi-institutional Studies, Helene Starks, MPH

### Posters

- The association between hospitalization for congestive heart failure and use of inhaled beta-agonists, Ed Udris, MPH
- Improving care to patients with ischemic heart disease: Experiences in a single network of them Veterans Health Administration, Sandra Pineros, MPH
- Primary care alcohol-related discussions with at-risk drinkers, Kathy Bradley, MD, MPH
- Two variations of recommended alcohol screening questionnaires did not improve screening accuracy in a VA general medical population, Kathy Bradley, MD, MPH
- Screening for PTSD in female VA patients: Validation of the PTSD checklist, Dorcas Dobie, MD
- Lipid measurement and management, Anne Sales, MSN, PhD



## Recent HSR&D Peer-Reviewed Publications

Au D, Lemaitre RM, Curtis JR, Smith NL, Psaty B. The risk of myocardial infarction associated with beta adrenoceptor agonists. *American Journal of Respiratory and Critical Care Medicine* 2000; 161: 827-830.

Every NR, Maynard C, Shulman K, Ritchie JL. The association between institutional primary angioplasty procedure volume and outcome in elderly Americans. *Journal of Invasive Cardiology* 2000; 12: 303-308.

Fihn SD. The quest to quantify. *JAMA* 2000, 283: 1740-1742.

Fihn SD. Does VA health care measure up? (Editorial) *The New England Journal of Medicine*. 2000, 243(26): 1963-1966.

Mayfield J, Reiber GE, Maynard C, Czerniecki J, Caps M, Sangeorzan B. Trends in lower extremity amputation in the Veteran Health Administration, 1989-1998. *Journal of Rehabilitation Research and Development* 2000; 37: 23-30.

Maynard C, Cox GB, Krupski A, Stark K. Utilization of services by persons discharged from involuntary chemical dependency treatment. *Journal of Addictive Diseases* 2000; 19: 83-93.

Maynard C, Every N, Chapko M, Ritchie JL. Decline in the number of low volume hospitals performing coronary angioplasty in California, 1989-1996. *American Journal of Cardiology* 2000; 85: 1026-1027.

Maynard C, Every N, Chapko MK, Ritchie JL. Coronary angioplasty outcomes in rural hospitals: Results from the Medicare Provider Analysis and Review files. *American Journal of Medicine* 2000; 109: 710-713.

Pearlman RA, Cain KC, Starks HE, Cole WG, Uhlmann RF, Patrick DL. Preferences for life-sustaining treatments in advance care planning and surrogate decision making. *Journal of Palliative Medicine* 2000; 3: 43-54.

Ritchie JL, Maynard C, Chapko M, Every NR, Martin D. The association between coronary angioplasty volumes and outcomes in the Health Care Cost and Utilization Project 1989-1994. *American Journal of Cardiology* 1999; 83: 494-497.

Sales A, Moscovice I, Lurie N. The implementation of continuous quality improvement programs in hospitals. *The Joint Commission Journal on Quality Improvement* 2000; 26(8): 476-487.

Sloan AJ, Kivlahan DR, Saxon AJ. Screening for bipolar disorder among treatment-seeking substance abusers. *American Journal of Alcohol Drug Dependency* 2000; 26: 13-23.

Smith NL, Reiber GE, Psaty B, Heckbert SR, Siscovick D, Ritchie JL, Every N, Koepsell T. Temporal trends in the medical treatment on unstable angina: 1990-1995. *American Journal of Cardiology* 1999; 84: 632-638.

Steele BG, Holt L, Belza B, Ferris S, Lakshminaryan S, Buchner DM. Quantitating physical activity in COPD using a triaxial accelerometer. *Chest* 2000; 117: 1359-1367.

Whitsel E, Boyko E, Siscovick DS. Reassessing the role of QTc in the diagnosis of autonomic failure among patients with diabetes mellitus. *Diabetes Care* 2000; 23(2): 241-247.